
SENATE BILL No. 221

DIGEST OF INTRODUCED BILL

Citations Affected: IC 27-8-10.

Synopsis: ICHIA assessments. Provides that reinsurers and stop loss insurers doing business in Indiana are members of the comprehensive health insurance association (ICHIA) and are subject to assessment for ICHIA's net losses. Provides that a member's share of ICHIA's net loss is assessed in proportion to the member's share of all individuals in Indiana who are covered by health insurance provided by a member plus all individuals in Indiana whose coverage is reinsured or supplemented by a member that is a reinsurer or a stop loss insurer. (The introduced version of this bill was prepared by the health finance commission.)

Effective: January 1, 2003.

Miller

January 7, 2002, read first time and referred to Committee on Health and Provider Services.

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PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type~~.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~this style type~~ reconciles conflicts between statutes enacted by the 2001 General Assembly.

SENATE BILL No. 221

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

1 SECTION 1. IC 27-8-10-1, AS AMENDED BY P.L.1-2001,
2 SECTION 33, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
3 JANUARY 1, 2003]: Sec. 1. (a) The definitions in this section apply
4 throughout this chapter.

5 (b) "Association" means the Indiana comprehensive health
6 insurance association established under section 2.1 of this chapter.

7 (c) "Association policy" means a policy issued by the association
8 that provides coverage specified in section 3 of this chapter. The term
9 does not include a Medicare supplement policy that is issued under
10 section 9 of this chapter.

11 (d) "Carrier" means **the following:**

12 **(1)** An insurer providing medical, hospital, or surgical expense
13 incurred health insurance policies.

14 **(2) A reinsurer that reinsures health insurance.**

15 **(3) A stop loss insurer.**

16 (e) "Church plan" means a plan defined in the federal Employee
17 Retirement Income Security Act of 1974 under 26 U.S.C. 414(e).



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(f) "Commissioner" refers to the insurance commissioner.

(g) "Creditable coverage" has the meaning set forth in the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1)).

(h) "Eligible expenses" means those charges for health care services and articles provided for in section 3 of this chapter.

(i) "Federally eligible individual" means an individual:

(1) for whom, as of the date on which the individual seeks coverage under this chapter, the aggregate period of creditable coverage is at least eighteen (18) months and whose most recent prior creditable coverage was under a:

(A) group health plan;

(B) governmental plan; or

(C) church plan;

or health insurance coverage in connection with any of these plans;

(2) who is not eligible for coverage under:

(A) a group health plan;

(B) Part A or Part B of Title XVIII of the federal Social Security Act; or

(C) a state plan under Title XIX of the federal Social Security Act (or any successor program);

and does not have other health insurance coverage;

(3) with respect to whom the individual's most recent coverage was not terminated for factors relating to nonpayment of premiums or fraud;

(4) who, if after being offered the option of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (29 U.S.C. 1191b(d)(1)), or under a similar state program, elected such coverage; and

(5) who, if after electing continuation coverage described in subdivision (4), has exhausted continuation coverage under the provision or program.

(j) "Governmental plan" means a plan as defined under the federal Employee Retirement Income Security Act of 1974 (26 U.S.C. 414(d)) and any plan established or maintained for its employees by the United States government or by any agency or instrumentality of the United States government.

(k) "Group health plan" means an employee welfare benefit plan (as defined in 29 U.S.C. 1167(1)) to the extent that the plan provides medical care payments to, or on behalf of, employees or their dependents, as defined under the terms of the plan, directly or through

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insurance, reimbursement, or otherwise.

(l) "Health care facility" means any institution providing health care services that is licensed in this state, including institutions engaged principally in providing services for health maintenance organizations or for the diagnosis or treatment of human disease, pain, injury, deformity, or physical condition, including a general hospital, special hospital, mental hospital, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing home, nursing home, intermediate care facility, tuberculosis hospital, chronic disease hospital, maternity hospital, outpatient clinic, home health care agency, bioanalytical laboratory, or central services facility servicing one (1) or more such institutions.

(m) "Health care institutions" means skilled nursing facilities, home health agencies, and hospitals.

(n) "Health care provider" means any physician, hospital, pharmacist, or other person who is licensed in Indiana to furnish health care services.

(o) "Health care services" means any services or products included in the furnishing to any individual of medical care, dental care, or hospitalization, or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any other services or products for the purpose of preventing, alleviating, curing, or healing human illness or injury.

(p) "Health insurance" means hospital, surgical, and medical expense incurred policies, nonprofit service plan contracts, health maintenance organizations, limited service health maintenance organizations, and self-insured plans. However, the term "health insurance" does not include short term travel accident policies, accident only policies, fixed indemnity policies, automobile medical payment, or incidental coverage issued with or as a supplement to liability insurance.

(q) "Insured" means all individuals who are provided qualified comprehensive health insurance coverage under an individual policy, including all dependents and other insured persons, if any.

(r) "Medicaid" means medical assistance provided by the state under the Medicaid program under IC 12-15.

(s) "Medical care payment" means amounts paid for:

- (1) the diagnosis, care, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;
- (2) transportation primarily for and essential to Medicare services referred to in subdivision (1); and

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(3) insurance covering medical care referred to in subdivisions (1) and (2).

(t) "Medically necessary" means health care services that the association has determined:

- (1) are recommended by a legally qualified physician;
- (2) are commonly and customarily recognized throughout the physician's profession as appropriate in the treatment of the patient's diagnosed illness; and
- (3) are not primarily for the scholastic education or vocational training of the provider or patient.

(u) "Medicare" means Title XVIII of the federal Social Security Act (42 U.S.C. 1395 et seq.).

(v) "Policy" means a contract, policy, or plan of health insurance.

(w) "Policy year" means a twelve (12) month period during which a policy provides coverage or obligates the carrier to provide health care services.

(x) "Health maintenance organization" has the meaning set out in IC 27-13-1-19.

(y) "Self-insurer" means an employer who provides services, payment for, or reimbursement of any part of the cost of health care services other than payment of insurance premiums or subscriber charges to a carrier. However, the term "self-insurer" does not include an employer who is exempt from state insurance regulation by federal law, or an employer who is a political subdivision of the state of Indiana.

(z) "Services of a skilled nursing facility" means services that must commence within fourteen (14) days following a confinement of at least three (3) consecutive days in a hospital for the same condition.

(aa) "Skilled nursing facility", "home health agency", "hospital", and "home health services" have the meanings assigned to them in 42 U.S.C. 1395x.

(bb) "Stop loss insurer" means an insurer that issues an insurance policy:

(1) to a policyholder that provides:

- (A) health care services;**
- (B) payment for health care services; or**
- (C) reimbursement of any part of the cost of health care services;**

other than payment of insurance premiums or subscriber charges to a carrier described in subsection (d)(1); and

(2) that provides coverage in the event of:

- (A) extraordinarily large claims; or**



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**(B) an extraordinarily large number of claims;
by individuals whose health care services are covered by the
policyholder described in subdivision (1).**

(cc) "Medicare supplement policy" means an individual policy of accident and sickness insurance that is designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, and surgical expenses of individuals who are eligible for Medicare benefits.

(dd) "Limited service health maintenance organization" has the meaning set forth in IC 27-13-34-4.

SECTION 2. IC 27-8-10-2.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2003]: Sec. 2.1. (a) There is established a nonprofit legal entity to be referred to as the Indiana comprehensive health insurance association, which must assure that health insurance is made available throughout the year to each eligible Indiana resident applying to the association for coverage. All carriers, health maintenance organizations, limited service health maintenance organizations, and self-insurers providing health insurance or health care services in Indiana must be members of the association. The association shall operate under a plan of operation established and approved under subsection (c) and shall exercise its powers through a board of directors established under this section.

(b) The board of directors of the association consists of seven (7) members whose principal residence is in Indiana selected as follows:

(1) Three (3) members to be appointed by the commissioner from the members of the association, one (1) of which must be a representative of a health maintenance organization.

(2) Two (2) members to be appointed by the commissioner shall be consumers representing policyholders.

(3) Two (2) members shall be the state budget director or designee and the commissioner of the department of insurance or designee.

The commissioner shall appoint the chairman of the board, and the board shall elect a secretary from its membership. The term of office of each appointed member is three (3) years, subject to eligibility for reappointment. Members of the board who are not state employees may be reimbursed from the association's funds for expenses incurred in attending meetings. The board shall meet at least semiannually, with the first meeting to be held not later than May 15 of each year.

(c) The association shall submit to the commissioner a plan of operation for the association and any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration

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of the association. The plan of operation becomes effective upon approval in writing by the commissioner consistent with the date on which the coverage under this chapter must be made available. The commissioner shall, after notice and hearing, approve the plan of operation if the plan is determined to be suitable to assure the fair, reasonable, and equitable administration of the association and provides for the sharing of association losses on an equitable, proportionate basis among the member carriers, health maintenance organizations, limited service health maintenance organizations, and self-insurers. If the association fails to submit a suitable plan of operation within one hundred eighty (180) days after the appointment of the board of directors, or at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall adopt rules under IC 4-22-2 necessary or advisable to implement this section. These rules are effective until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner. The plan of operation must:

- (1) establish procedures for the handling and accounting of assets and money of the association;
- (2) establish the amount and method of reimbursing members of the board;
- (3) establish regular times and places for meetings of the board of directors;
- (4) establish procedures for records to be kept of all financial transactions, and for the annual fiscal reporting to the commissioner;
- (5) establish procedures whereby selections for the board of directors will be made and submitted to the commissioner for approval;
- (6) contain additional provisions necessary or proper for the execution of the powers and duties of the association; and
- (7) establish procedures for the periodic advertising of the general availability of the health insurance coverages from the association.

(d) The plan of operation may provide that any of the powers and duties of the association be delegated to a person who will perform functions similar to those of this association. A delegation under this section takes effect only with the approval of both the board of directors and the commissioner. The commissioner may not approve a delegation unless the protections afforded to the insured are substantially equivalent to or greater than those provided under this chapter.



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(e) The association has the general powers and authority enumerated by this subsection in accordance with the plan of operation approved by the commissioner under subsection (c). The association has the general powers and authority granted under the laws of Indiana to carriers licensed to transact the kinds of health care services or health insurance described in section 1 of this chapter and also has the specific authority to do the following:

- (1) Enter into contracts as are necessary or proper to carry out this chapter, subject to the approval of the commissioner.
- (2) Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against participating carriers.
- (3) Take legal action necessary to avoid the payment of improper claims against the association or the coverage provided by or through the association.
- (4) Establish a medical review committee to determine the reasonably appropriate level and extent of health care services in each instance.
- (5) Establish appropriate rates, scales of rates, rate classifications and rating adjustments, such rates not to be unreasonable in relation to the coverage provided and the reasonable operational expenses of the association.
- (6) Pool risks among members.
- (7) Issue policies of insurance on an indemnity or provision of service basis providing the coverage required by this chapter.
- (8) Administer separate pools, separate accounts, or other plans or arrangements considered appropriate for separate members or groups of members.
- (9) Operate and administer any combination of plans, pools, or other mechanisms considered appropriate to best accomplish the fair and equitable operation of the association.
- (10) Appoint from among members appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the association, policy and other contract design, and any other function within the authority of the association.
- (11) Hire an independent consultant.
- (12) Develop a method of advising applicants of the availability of other coverages outside the association and may promulgate a list of health conditions the existence of which would deem an applicant eligible without demonstrating a rejection of coverage by one (1) carrier.

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(13) Provide for the use of managed care plans for insureds, including the use of:

- (A) health maintenance organizations; and
- (B) preferred provider plans.

(14) Solicit bids directly from providers for coverage under this chapter.

(f) Rates for coverages issued by the association may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage. Separate scales of premium rates based on age apply for individual risks. Premium rates must take into consideration the extra morbidity and administration expenses, if any, for risks insured in the association. The rates for a given classification may not be more than one hundred fifty percent (150%) of the average premium rate for that class charged by the five (5) carriers with the largest premium volume in the state during the preceding calendar year. In determining the average rate of the five (5) largest carriers, the rates charged by the carriers shall be actuarially adjusted to determine the rate that would have been charged for benefits identical to those issued by the association. All rates adopted by the association must be submitted to the commissioner for approval.

(g) Following the close of the association's fiscal year, the association shall determine the net premiums, the expenses of administration, and the incurred losses for the year. Any net loss shall be assessed by the association to all members in proportion to their respective shares of ~~total health insurance premiums~~; the sum of:

- (1) the number of individuals in Indiana who are covered under health insurance provided by a member; plus**
- (2) the number of individuals in Indiana whose coverage for health care services is reinsured or supplemented by a member that is a reinsurer or a stop loss insurer, excluding individuals who are described in subdivision (1);**

~~excluding premiums for individuals who are covered under Medicaid contracts with the state of Indiana received in Indiana during the calendar year (or with paid losses in the year) coinciding with or ending during the fiscal year of the association or any other equitable basis as may be provided in the plan of operation. For self-insurers, health maintenance organizations, and limited service health maintenance organizations that are members of the association, the proportionate share of losses must be determined through the application of an equitable formula based upon claims paid, excluding claims for Medicaid contracts with the state of Indiana; or the value of services provided.~~ In sharing losses, the association may abate or defer in any

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part the assessment of a member if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. The association may also provide for interim assessments against members of the association if necessary to assure the financial capability of the association to meet the incurred or estimated claims expenses or operating expenses of the association until the association's next fiscal year is completed. Net gains, if any, must be held at interest to offset future losses or allocated to reduce future premiums. Assessments must be determined by the board members specified in subsection (b)(1), subject to final approval by the commissioner.

(h) The association shall conduct periodic audits to assure the general accuracy of the financial data submitted to the association, and the association shall have an annual audit of its operations by an independent certified public accountant.

(i) The association is subject to examination by the department of insurance under IC 27-1-3.1. The board of directors shall submit, not later than March 30 of each year, a financial report for the preceding calendar year in a form approved by the commissioner.

(j) All policy forms issued by the association must conform in substance to prototype forms developed by the association, must in all other respects conform to the requirements of this chapter, and must be filed with and approved by the commissioner before their use.

(k) The association may not issue an association policy to any individual who, on the effective date of the coverage applied for, does not meet the eligibility requirements of section 5.1 of this chapter.

(l) The association shall pay an agent's referral fee of twenty-five dollars (\$25) to each insurance agent who refers an applicant to the association if that applicant is accepted.

(m) The association and the premium collected by the association shall be exempt from the premium tax, the gross income tax, the adjusted gross income tax, supplemental corporate net income, or any combination of these, or similar taxes upon revenues or income that may be imposed by the state.

(n) Members who after July 1, 1983, during any calendar year, have paid one (1) or more assessments levied under this chapter may either:

(1) take a credit against premium taxes, gross income taxes, adjusted gross income taxes, supplemental corporate net income taxes, or any combination of these, or similar taxes upon revenues or income of member insurers that may be imposed by the state, up to the amount of the taxes due for each calendar year in which the assessments were paid and for succeeding years until the

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1 aggregate of those assessments have been offset by either credits
2 against those taxes or refunds from the association; or

3 (2) any member insurer may include in the rates for premiums
4 charged for insurance policies to which this chapter applies
5 amounts sufficient to recoup a sum equal to the amounts paid to
6 the association by the member less any amounts returned to the
7 member insurer by the association, and the rates shall not be
8 deemed excessive by virtue of including an amount reasonably
9 calculated to recoup assessments paid by the member.

10 (o) The association shall provide for the option of monthly
11 collection of premiums.

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